DEPARTMENT OF DEVELOPMENTAL SERVICES (DDS)
WAIVER SERVICES
APPLICATION FOR
EXISTING AGENCY QUALIFIED PROVIDERS

1. APPLICANT INFORMATION:

Identify the partnership, corporation, or governmental agency applying to lawfully establish, conduct, and provide service.

Name:		
Address:		
City:	State:	Zip:
FEIN #:	Phone:	

Connecticut Administrator

Identify the person responsible for the overall management and oversight of the service(s) to be operated in Connecticut by the applicant.

Name:		
Title:		
Address:		
City:	State:	Zip:
Phone:	Fax Number:	
Email Address:		

Organizational Structure

Identify the organizational structure of the applicant's governing body.

Check one (1) of the following:

☐ Individual (proprietorship) ☐ Partnership
☐ Non-Profit Corporation ☐ For-Profit Corporation
☐ Public Agency

If the applicant has a parent corporation, please provide the following information:

Name of Corporation:		
Address:		
City:	State:	Zip:
Phone:	Fax Number:	
Principle of the Entity:	Title:	
Social Security #:	Phone:	
Email Address:		

Ownership Information

If the business is other than a not for profit, please list the name(s) and Social Security Numbers for individuals who own at least 5% interest in the business.

Name	Address	Soc Sec #	Percent
			%
			%
			%
			%
			%

Use separate sheet of paper if additional space is needed.

2. PROVIDER AGENCY ACKNOWLEDGEMENT

I certify that the information on this application are true and complete to the best of my knowledge and are made in good faith. I understand the partnership, corporation, or government agency is subject to disqualification if it knowingly makes any misstatement of fact. All statements made on this application, including employment information, are subject to verification as a condition of becoming a qualified provider.

I understand that the provider agency is responsible for submitting to DDS verification and documentation of its qualifications to render the Waiver Services indicated on this application.

_____

Printed Name and Title

_____ _____

Signature of Principal of the Entity for Provider Agency Date

3. ADMINISTRATOR'S CERTIFICATION

CRIMINAL CONVICTIONS: Answers to the following question will be considered for qualification purposes.

Have you ever been CONVICTED of an offense against criminal or military law, or are there criminal charges currently pending against you? (Exclude minor traffic violations or any offense settled in juvenile court or under a youth offender law).

Principle of the Entity ☐ Yes ☐ No **Connecticut Administrator** ☐ Yes ☐ No

If "Yes", please attach a detailed explanation about the nature of the conviction, degree of rehabilitation and time since release.

Special Note: You are **not** required to disclose the existence of any arrest, criminal charge or conviction, the records of which have been erased pursuant to Connecticut General Statutes §46b-146, 54-76o, or 54-142a. If your criminal records have been erased pursuant to one of these statutes, you may swear under oath that you have never been arrested. Criminal records that may be erased are records pertaining to a finding of delinquency or that a child was a member of a family with service needs (C.G.S. §46b-146), an adjudication as a youthful offender (C.G.S. §54-76o), a criminal charge that has been dismissed or nolled, a criminal charge for which the person has been found not guilty or a conviction for which the person received an absolute pardon (C.G.S. §54-142a).

I certify that the information regarding criminal convictions and employment history is true and complete to the best of my knowledge and is made in good faith. I understand the partnership, corporation, association, or governmental agency is subject to disqualification if I knowingly make any misstatement of fact. All statements made in reference to criminal convictions or employment history in regards to this application are subject to verification as a condition of becoming a qualified provider. I agree that I will notify the Operation Center immediately in writing if I am arrested or convicted of a crime.

_____ _____

Signature Principal of the Entity For Provider Agency Title

_____ _____ _____

Date of Birth Social Security Number Date

_____ _____

Signature Connecticut Administrator For Provider Agency Title

_____ _____ _____

Date of Birth Social Security Number Date

INSTRUCTIONS:

A completed Department of Developmental Services "Application for Existing Agency Qualified Providers" form along with any applicable attachments should be submitted to:

Maureen Prewitt
Department of Developmental Services
Operation Center
25 Creamery Road
Cheshire, CT 06410